■ PREPARTICIPATION PHYSICAL EVALUATION

HISTORY FORM

Note: Complete and sign this form (with your paren Name:	Date of birth:
Date of examination:	
	How do you identify your gender? (F, M, or other):
List past and current medical conditions.	
Have you ever had surgery? If yes, list all past surg	ical procedures.
Medicines and supplements: List all current prescri	iptions, over-the-counter medicines, and supplements (herbal and nutritional).
Do you have any allergies? If yes, please list all yo	our allergies (ie, medicines, pollens, food, stinging insects).
Patient Health Questionnaire Version 4 (PHQ-4)	had and by any of the following making 2 / Circle same 1

Over the last 2 weeks, how often have you been bothered by any of the following problems: (Circle response.)							
	Not at all	Several days	Over half the days	Nearly every day			
Feeling nervous, anxious, or on edge	0	1	2	3			
Not being able to stop or control worrying	0	1	2	3			
Little interest or pleasure in doing things	0	1	2	3			
Feeling down, depressed, or hopeless	0	1	2	3			
(A sum of ≥3 is considered positive on either s	ubscale (question	ns 1 and 2, or que	stions 3 and 4] for scre	ening purposes.)			

(Exp	ERAL QUESTIONS lain "Yes" answers at the end of this form. e questions if you don't know the answer.)	Yes	No
1.	Do you have any concerns that you would like to discuss with your provider?		
2.	Has a provider ever denied or restricted your participation in sports for any reason?		
3.	Do you have any ongoing medical issues or recent illness?		
HEA	RT HEALTH QUESTIONS ABOUT YOU	Yes	No
4.	Have you ever passed out or nearly passed out during or after exercise?		
5.	Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
6.	Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?		
7.	Has a doctor ever told you that you have any heart problems?		
8.	Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography.		

HEART HEALTH QUESTIONS ABOUT YOU (CONTINUED)	Yes	No
Do you get light-headed or feel shorter of breath than your friends during exercise?	1	
10. Have you ever had a seizure?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	Yes	No
11. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 years (including drowning or unexplained car crash)?		
12. Does anyone in your family have a genetic hear problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)?		980
13. Has anyone in your family had a pacemaker or an implanted delibrillator before age 35?		

BOI	NE AND JOINT QUESTIONS	Yes	No	MEDIC
14.	Have you ever had a stress fracture or an injury to a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game?			25. E
15.	Do you have a bone, muscle, ligament, or joint injury that bothers you?			27. A
MEC	PICAL QUESTIONS	Yes	No	28. F
16.	Do you cough, wheeze, or have difficulty breathing during or after exercise?			FEMA
1 <i>7</i> .	Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?			29. H
18.	Do you have groin or testicle pain or a painful bulge or hemia in the groin area?			31. V
19.	Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant <i>Staphylococcus aureus</i> (MRSA)?			32. F
20,	Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?			
21.	Have you ever had numbness, had tingling, had weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling?			
22.	Have you ever become ill while exercising in the heat?			\(\frac{1}{2}\)
23.	Do you or does someone in your family have sickle cell trait or disease?			
24.	Have you ever had or do you have any prob- lems with your eyes or vision?			

	ICAL QUESTIONS (CONTINUED)	Yes	N
25.	Do you worry about your weight?		П
26.	Are you trying to or has anyone recommended that you gain or lose weight?		
27.	Are you on a special diet or do you avoid certain types of foods or food groups?		
28.	Have you ever had an eating disorder?		
FEM	ALES ONLY	Yes	N
29.	Have you ever had a menstrual period?		
30.	How old were you when you had your first menstrual period?		
31.	When was your most recent menstrual period?		
22	How many periods have you had in the past 12		
	months?		
	months?		
	months?		

I hereby state that,	to the best of my	knowledge, my	answers to the c	questions on this	form are complete
and correct.					-

Signature of athlete:	
ignature of parent or guardian:	
Date:	

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■ PREPARTICIPATION PHYSICAL EVALUATION PHYSICAL EXAMINATION FORM

Name: ___

Signature of health care professional: _

PHYSICIAN REMINDERS						
1. Consider additional questional	ons on more-sensitiv	ve issues.				
 Do you feel stressed ou 						
 Do you ever feel sad, h 						
 Do you feel safe at you 						
		s, chewing tobacco, snuff, or dip	ś			
		ving tobacco, snuff, or dip?				
Do you drink alcohol o Have you ever taken as				42		
Have you ever taken as	nv sunnlements to h	used any other performance-enh elp you gain or lose weight or in	ancing suppleme	eni?		
Do you wear a seat bel			iipiove your peri	Official		
		ar symptoms (Q4–Q13 of Histor	y Form).			
EXAMINATION	SESSION CONTRACTOR	TANK THE PROPERTY OF THE PARTY		Spring and the second	ASSESSED	SHE ATTEMATICAL PROPERTY.
Height:	Weight:				entrace in 1 Was	
BP: / [/]) Pulse:	Vision: R 20/	1.20/	<u> </u>	1 54	
MEDICAL	roise.	Vision: R 2U/	L 20/	Correcte		
But and the second second second	MACKET CHICKET				NORMAL	ABNORMAL FINDINGS
Appearance	dioris biobarched	palate, pectus excavatum, arach		باستاد ا		
myopia, mitral valve prolag	se [MVP], and apri	palaie, pecius excuvaium, aracii fic insufficiency)	повастуту, турет	ricocity,		
Eyes, ears, nose, and throat	, , , , , , , , , , , , , , , , , , ,	in instruction ()	 			
Pupils equal				ŀ		
Hearing						
Lymph nodes						
Heart ^o						
Murmurs (auscultation stand	ding, auscultation si	upine, and ± Valsalva maneuver	}			
Lungs						
Abdomen		····				
Skin			-		-	17
Herpes simplex virus (HSV)	, lesions suggestive	of methicillin-resistant Staphyloc	occus aureus (Mi	RSA), or		
tinea corporis						375.7
Neurological			•			
MUSCULOSKELETAL					NORMAL	ABNORMAL FINDINGS
Neck			-			
Back			-			
Shoulder and arm			_			
Elbow and forearm		· · · · · · · · · · · · · · · · · · ·				
Wrist, hand, and fingers						
Hip and thigh		<u></u>				
Knee						
Leg and ankle						
Foot and toes						
Functional					· · ·	
Double-leg squat test, single	e-leg squat test, and	box drop or step drop test		1		
Consider electrocardiography			for abnormal car	rdiac history	or examin	nation findings, or a combi-
nation of those.						
Name of health care professions	al (print or type);				Da	te:
Address:				Pho	Je.	

Date of birth:

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■ PREPARTICIPATION PHYSICAL EVALUATION

MEDICAL ELIGIBILITY FORM

Name: ___ ☐ Medically eligible for all sports without restriction ☐ Medically eligible for all sports without restriction with recommendations for further evaluation or treatment of ☐ Medically eligible for certain sports □ Not medically eligible pending further evaluation Not medically eligible for any sports Recommendations: I have examined the student named on this form and completed the preparticipation physical evaluation. The athlete does not have apparent clinical contraindications to practice and can participate in the sport(s) as outlined on this form. A copy of the physical examination findings are on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the medical eligibility until the problem is resolved and the potential consequences are completely explained to the athlete (and parents or guardians). Address: ______ Phone; _____ ______, MD, DO, NP, or PA Signature of health care professional: **SHARED EMERGENCY INFORMATION** Allergies: ______ Medications: Other information:

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